



# Bupa Breast Health

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Please complete this questionnaire and bring it with you



# Your health check questionnaire

ID number

The Bupa Breast Health check has been designed to provide a thorough breast check and look for signs of any breast problems.

**Please complete the blue sections of this confidential questionnaire as fully as possible and bring it with you to your health check.**

Please leave grey areas of the questionnaire for the doctor or nurse to add their comments.

Don't worry if there are any questions you can't answer - these can be discussed during your assessment.

Please use BLOCK CAPITALS.

## Your details

Title Mrs  Miss  Ms  Other (please indicate)

First name  Surname

Date of birth  /  /  Age  Previous name

Home address

Postcode

Home telephone number  Work telephone number

Mobile telephone number  Email

Are you covered by private medical insurance? Bupa  Membership number  Other  No

Date questionnaire completed  /  /

Please complete the following if your employer is paying for this assessment:

Company name

Company address

Postcode

If your company is paying for this health check they will be aware of your attendance, please tick to confirm that you are aware of this.

(please tick):

## Keeping your GP informed

It is good practice for your GP to be kept informed of all aspects relating to your health. Please complete the information below if you are happy for us to send your results to your GP and advise him or her of any abnormalities or significant results that may require follow-up investigation or treatment.

GP name

GP address

Postcode

GP telephone number

## Monitoring further action

Bupa monitors what happens to customers after certain screening tests and certain abnormal results (eg mammography).

This allows us to check on the quality of these tests and ensure that any necessary action has taken place.

Please indicate whether or not you are happy for us to contact the following:

You Yes  No  Your GP Yes  No  Your specialist Yes  No

Please sign  Date  /  /

This visit date  Name of doctor

First visit Yes  No  Name of health adviser

If no, date of last visit

## Information sheet

It is important to have read the information sheet to understand the tests we will carry out on you.

I confirm that I have received and read the following information sheet (please tick):

Important information for women about breast screening and mammography

If you have any concerns about the information contained in this sheet, please ask

Please sign

Date  /  /

## Please tell us your reason for attending

Please outline below what you would like to get out of this breast check

If any medical symptoms you have do not resolve as expected or any new symptoms arise, you should seek further medical advice.

## Family history

Has any member of your family had any of the following:

Breast cancer

Yes

No

Details:

Ovarian cancer

Yes

No

Details:

## Your lifestyle

### Smoking

Do you smoke?

Never

Given up

Yes

### Alcohol

How many units of alcohol do you typically drink over the course of a week?

(A bottle of wine typically contains around nine units of alcohol, a pint of standard strength beer around 2.5 units and a pint of cider around three units. Spirits and fortified wines contain one unit of alcohol per pub measure)

### Your diet

Do you limit your intake of saturated fat?

Yes

No

eg butter, cream, cakes, eggs and fatty meats

Do you eat five or more portions of fruit and/or vegetables each day?

Yes

No

Clinical findings

## Your medical history

Do you have any concerns about your breasts?

Yes  No

*If yes, please give details*

Have you ever had a mammogram?

Yes  No

*If yes, when and where was your last one performed and what was the result?*

Have you ever had a breast problem or needed breast surgery?

Yes  No

*If yes, please give details*

Are you breast aware and do you know how to examine your breasts?

Yes  No

Has any member of your family had cancer of the breast, ovary or any other gynaecological cancer?

Yes  No

*If yes, please give age and details*

Is breast tenderness a problem?

Yes  No

*If yes, please give details*

Are you taking hormone replacement therapy (HRT)?

Yes  No

*If yes, please give name of product*

When was your last period?

Date  /  /

Have your recent periods been regular?

Yes  No

Do you have any problems with your periods?

Yes  No

Are you using contraception?

Yes  No

Have you ever been pregnant?

Yes  No

*If yes, please give age and details*

## Clinical Findings

**Thank you for completing this questionnaire.**  
The remaining pages are for your Bupa nurse to complete.

# Consent

## Physical examinations

If you will be undertaking a full examination please ensure you have the customer's agreement to this.

Physical examination has been discussed with the customer and permission obtained    Yes        No   

## Chaperone

A chaperone has been offered during the physical examination    Yes        No   

A chaperone has been requested during this examination    Yes        No   

by    Doctor        Customer   

If yes, then record the name of the chaperone in the box below

# Clinical findings

Build/shape:

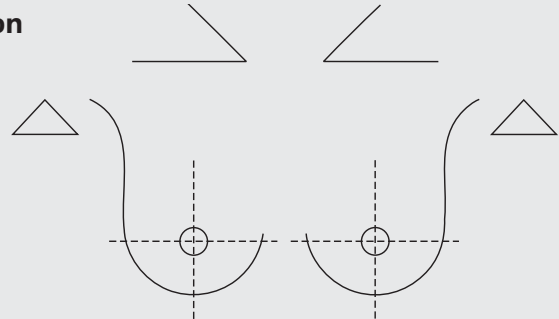
BP:

Pulse/rhythm:

Mood and rapport:

Past breast history:

## Clinical examination



Present symptoms:

Hormones Yes  No

### Clinical examination:

(If abnormal please give details and mark asymmetry, scars, skin lesions, lumps, tenderness, etc. on diagram)

Clinical summary:	Right	Left		Right	Left
Normal	<input type="checkbox"/>	<input type="checkbox"/>	Nipple normal	<input type="checkbox"/>	<input type="checkbox"/>
Benign abnorm.	<input type="checkbox"/>	<input type="checkbox"/>	Nipple inverted	<input type="checkbox"/>	<input type="checkbox"/>
Suspicious abnorm.	<input type="checkbox"/>	<input type="checkbox"/>	Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>
Mammography	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

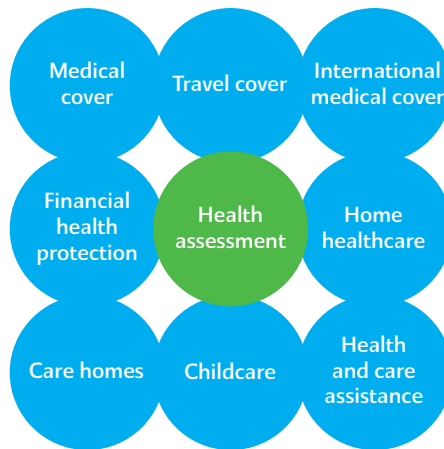
Reason:

Recommendation: Screening review  Referral  Clinical re-check  Mammre-check

Doctor's / Wellwoman Sister's signature \_\_\_\_\_

Date \_\_\_\_\_

## Notes



## The world of Bupa

**Call 0800 12 34 56**

**for information on Bupa Wellness**

Lines open 8am - 8pm weekdays.

Calls will be recorded and may be monitored.

[www.bupa.co.uk/wellness](http://www.bupa.co.uk/wellness)

**Bupa Wellness offers you:**

- Health assessments
- Occupational health
- Stress management
- Dental services
- Musculoskeletal services
- Private GP services

**Call 0800 00 10 10**

**for information on all other Bupa services**

Lines open 24 hours.

Calls will be recorded and may be monitored.

[www.bupa.com](http://www.bupa.com)

